ADIRONDACK SURGICAL GROUP

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use and disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Office Policy in accordance with Public Health Law(Section 17&18)requires a $0.75 cents per page fee for copies of these medical records.

Patient Name:_____ Date of Birth:_____

Person(s)/organization authorized to use/disclose Information (from):_____
_____
_____
_____

Person(s)/organization authorized to receive the Information:_____
_____
_____
_____

Information that may be used/disclosed: (Include dates if possible)

( ) Records of Visits (all)_____
( ) Records of Visits (specific) _____
( ) Operative Report(s) _____
( ) Medication Record _____
( ) Other_____

( ) Laboratory _____
( ) X-ray, MRI, CT_____
( ) Entire Medical Record _____
( ) Statement of Charges/Payment _____

1. The health plan or health care provider must complete the following:
   a. The information will be used/disclosed for the following purposes:
      ( ) Continued Patient Care ( ) Attorney/Legal ( ) Disability Determination
      ( ) Personal Use ( ) Insurance Claim ( ) Other

   b. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing health information described above?
      ( ) YES _____ ( ) NO _____

2. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

3. I understand that I may inspect and copy any information to be used or disclosed.

4. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires_____.

5. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.

_____ _____
Signature of Patient or Representative Today's Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient